DOH-1961 (8/2011)

RECORDED DISTRICT 3264

REGISTER NUMBER 273

NEW YORK STATE
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

131-2018-00029754
STATE FILE NUMBER

1. NAME: FIRST MIDDLE LAST: Gail Catherine Harter
2. SEX: MALE ☐1 FEMALE ☒2
3A. DATE OF DEATH: MONTH 04 DAY 20 YEAR 2018
3B. HOUR: 03:14 PM

4A. PLACE OF DEATH (Check one): HOSPITAL DOA ☐ ER ☐; HOSPITAL OUTPATIENT ☐; HOSPITAL INPATIENT ☒; NURSING HOME ☐; PRIVATE RESIDENCE ☐; HOSPICE FACILITY ☐; OTHER (Specify) ☐
4B. IF FACILITY, DATE ADMITTED: MONTH 04 DAY 20 YEAR 2018
4C. NAME OF FACILITY (If not facility, give address): Faxton-St Lukes Healthcare - St Lukes Division
4D. LOCALITY (Check one and specify): CITY ☐ VILLAGE ☐ TOWN ☐ New Hartford Town
4E. COUNTY OF DEATH: Oneida
4F. MEDICAL RECORD NO.: 188980
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☐ YES ☒ Charles T. Sitrin HCC,

5. DATE OF BIRTH: MONTH DAY YEAR [redacted]
6A. AGE IN YEARS: 77 yrs.
6B. IF UNDER 1 YEAR ENTER: months days
6C. IF UNDER 1 DAY ENTER: hours minutes
7A. CITY AND STATE OF BIRTH (If not USA, Country and Region/Province): Utica, New York
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

DECEDENT

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO ☒0 YES ☐1
9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. A ☒ No, not Spanish/Hispanic/Latino; B ☐ Yes, Mexican, Mexican American, Chicano; C ☐ Yes, Puerto Rican; D ☐ Yes, Cuban; E ☐ Yes, Other Spanish/Hispanic/Latino (Specify)
10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be: A ☒ White/Caucasian; B ☐ Black or African American; C ☐ Asian Indian; D ☐ Chinese; E ☐ Filipino; F ☐ Japanese; G ☐ Korean; H ☐ Vietnamese; J ☐ Native Hawaiian; K ☐ Guamanian or Chamorro; M ☐ Samoan; N ☐ American Indian or Alaska Native (specify); P ☐ Other Asian (specify); ☐ Other Pacific Islander (specify); S ☐ Other (specify)
11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death. 1 ☐ ≤ 8th grade; 2 ☐ 9th-12th grade; no diploma; 3 ☒ High school graduate or GED; 4 ☐ Some college credit, but no degree; 5 ☐ Associate's degree; 6 ☐ Bachelor's degree; 7 ☐ Master's degree; 8 ☐ Doctorate/Professional degree
12. SOCIAL SECURITY NUMBER:
13. MARITAL STATUS: NEVER MARRIED ☐1 MARRIED ☐2 WIDOWED ☒3 DIVORCED ☐4 SEPARATED ☐5
14. SURVIVING SPOUSE: Enter birth name of spouse if married or separated
15A. USUAL OCCUPATION (Do not enter retired): Certified Nursing Assistant
15B. KIND OF BUSINESS OR INDUSTRY: Healthcare
15C. NAME AND LOCALITY OF COMPANY OR FIRM: Mohawk Valley Nursing Home, Ilion, New York
16A. RESIDENCE (State or Country): [redacted]
16B. County or Region/Province (not USA):
16C. LOCALITY (Check one and specify): CITY VILLAGE TOWN [redacted]
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☐YES ☐NO IF NO, SPECIFY TOWN:
16D. STREET AND NUMBER OF RESIDENCE: [redacted]
16E. ZIP CODE: [redacted]

TO BE LEGAL AND VALID THIS DOCUMENT MUST BEAR THE OFFICIAL SEAL OF REGISTRAR TOWN OF HARTFORD

PARENTS

17. BIRTH NAME OF FATHER / PARENT: FIRST MI LAST: Leo Edward Dolin
18. BIRTH NAME OF MOTHER / PARENT: FIRST MI LAST: Mary Ann Foy
19A. NAME OF INFORMANT: Sally Juliano
19B. MAILING ADDRESS (include zip code): [redacted]

DISPOSITION

20A. 1 ☐ BURIAL 2 ☒ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☐ ENTOMBMENT — MONTH 04 DAY 27 YEAR 2018
20B. PLACE OF BURIAL, CREMATION, REMOVAL, OR OTHER DISPOSITION: Waterville Crematory
20C. LOCATION (City or town and state): Waterville Village, New York
21A. NAME AND ADDRESS OF FUNERAL HOME: Fenner Funeral Home Inc, 115 Court St, Herkimer, NY 13350
21B. REGISTRATION NUMBER: 00573
22A. NAME OF FUNERAL DIRECTOR: Ronald P Hess Jr
22B. SIGNATURE OF FUNERAL DIRECTOR: ▶ *Ronald P Hess Jr Electronically Signed*
22C. REGISTRATION NUMBER: 11606
23A. SIGNATURE OF REGISTRAR: ▶ *Gail Wolanin Young Electronically Signed*
23B. DATE FILED: MONTH 04 DAY 23 YEAR 2018
24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Rebecca Ann Emery
24B. DATE ISSUED: MONTH 04 DAY 23 YEAR 2018

CERTIFICATION BY ANYONE OTHER THAN THE REGISTRAR SHALL INVALIDATE THIS DOCUMENT

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

CERTIFIER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: Finian Oparah, MD
License No.: 287483
Signature: ▶ Finian Oparah MD *Electronically Signed*
Month 04 Day 23 Year 2018
Certifier's Title: 0 ☒ Attending Physician; 0 ☐ Physician acting on behalf of Attending Physician; 1 ☐ Coroner; 2 ☐ Medical Examiner / Deputy Medical Examiner
Address: 1656 Champlin Ave, New Hartford Town, NY 13502
25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Signature: ▶ Month Day Year
25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Address:
26A. Attending physician attended deceased: FROM Month 04 Day 20 Year 2018 TO Month 04 Day 20 Year 2018
26B. Deceased last seen alive by attending physician: Month 04 Day 20 Year 2018
26C. Pronounced Dead: Month 04 Day 20 Year 2018 AT Time 03:14 PM
27. MANNER OF DEATH: NATURAL CAUSE ☒1 ACCIDENT ☐2 HOMICIDE ☐3 SUICIDE ☐4 UNDETERMINED CIRCUMSTANCES ☐5 PENDING INVESTIGATION ☐6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☐ NO 1 ☒ YES
29A. AUTOPSY? NO ☒0 YES ☐1 REFUSED ☐2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ NO 1 ☐ YES

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).)

PART I. IMMEDIATE CAUSE:	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) Cardiac arrest	30mins
DUE TO OR AS A CONSEQUENCE OF: (B) severe sepsis	8hours
DUE TO OR AS A CONSEQUENCE OF: (C)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A):
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☒ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN
31A. IF INJURY, DATE: MONTH DAY YEAR
HOUR:
31B. INJURY LOCALITY (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO ☐0 YES ☐1
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian 4 ☐ OTHER (specify)
32. WAS DECEDENT HOSPITALIZED IN LAST 2 MONTHS? NO ☐0 YES ☒1
33A. IF FEMALE: 0 ☒ Not pregnant within past year; 1 ☐ Pregnant at time of death; 2 ☐ Not pregnant, but pregnant within 42 days of death; 3 ☐ Not pregnant, but pregnant 43 days to 1 year before death; 4 ☐ Unknown if pregnant within past year
33B. DATE OF DELIVERY: MONTH DAY YEAR

Left margin: RESIDENCE; NCHS; 4C; 4G; 7A; 7B; 5; 25; 30; 31; 31B; OR; DS; OCOD; CANCER; DATE OF DEATH; AM PM; For use by physician or institution; NAME OF DECEDENT; TIME OF DEATH